Local Government Health Plan
Membership Correction/Change Form

Member Name: _____SSN _____

Unit Name or Number _____

Employee Termination Date: _____ Reason _____
Termination will be effective at midnight of the date of termination. *Attach documentation, if applicable.*

Address Change: Date Effective: _____ Member ☐ Dependents ☐

New Address: _____

Qualifying Change in Status (select one) Month/Day/Year

☐ Birth/adoption/legal custody/adjudicated child
- *attach documentation* _____

☐ Marriage, *attach copy of marriage license* _____
Change Name to: _____

☐ Divorce/annulment/legal separation – *attach documentation* _____
Change Member Name to: _____

☐ Member's Employment Status: Part-time to Full-time _____

☐ Member's Employment Status: Full-time to Part-time _____

☐ Member going on Leave of Absence _____

☐ Spouse gains employment/Group Insurance Coverage _____

☐ Spouse loses employment/Loses other coverage _____

☐ Spouse's employer increases premiums 30% or greater or significantly decreases coverage/Member's premium increases 30% or greater _____

☐ Coordination of Spouse's Annual Election Period _____

☐ Change in Member/Spouse/Dependent's County of Residence or County of Work Location _____

☐ Primary Care Provider leaving network (HMO or OAP only) _____

☐ Change in Medicaid status _____

☐ Change in Medicare status
- *complete **Medicare Status** section below* _____

☐ Member's employment status changes: Active to Annuitant _____

☐ Member loses other coverage _____

☐ Military Call-Up _____

☐ Other [1] _____

[1] Explain: _____

Qualifying Change in Status Required Action

☐ Add Member: *complete enrollment forms*
☐ Add Dependent(s): *Please complete a dependent enrollment form for each dependent and attach required documentation.*
☐ Drop Dependent(s): Reason: _____
Dependent Name _____ SSN _____
Dependent Name _____ SSN _____
Dependent Name _____ SSN _____
Dependent Name _____ SSN _____
☐ COBRA Effective Date: _____

Medicare Status – *Attach a copy of Medicare card(s)*

☐ Medicare Eligible 65+
☐ Medicare Disability
☐ End Stage Renal Disease
☐ Medicare Ineligible

Complete the following:
Part A (begin date) _____
Part B (begin date) _____
Part D (begin date) _____
Part A Free (Y/N) _____

Additional Comments/Other

_____
_____
_____

Member's Signature: _____ Date: _____

HPR Signature: _____ Date: _____

HPR Phone Number: _____

Attachments: (*documentation*) _____

Note: Change in Status requires Member's Signature

Date sent to LGHP: _____

Mail to: LGHP
801 South 7th Street
Springfield, Illinois 62703

Fax to: 217/524-7541